Assessment of clinical competence: reliability, validity, feasibility and educational impact of the mini-CEX

Propositions

Regarding the dissertation

Assessment of clinical competence: Reliability, Validity, Feasibility and Educational Impact of the mini-CEX

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1. An evaluation tool to measure clinical competence may vary in appropriateness depending upon the target competency, and the appropriateness of the evaluation method depends on its utility.
2. The utility of workplace-based assessment appears to be determined by the users of the instrument rather than by the instrument.
3. Assessors are not passive 'instruments', but rather 'creators' of their own judgments.
4. A good understanding of the factors impacting on assessors' judgments and ratings after direct observation is crucial and should be taken into account by those developing and organizing assessor training sessions.
5. Assessor training may have some advantages. First, because it can improve inter-rater agreement. Second, because training sessions offer an opportunity to extensively introduce, explain, and discuss the method with designated assessors, thereby possibly enhancing examiners' commitment to the application of the format.
6. What is considered noise or error in psychometric theory may be the natural result of idiosyncratic experiences and created realities not only on the part of the learner but equally on the part of the assessor.
7. Raters tended to make categorical judgments as part of impression formation. Assessment systems that require ordinal ratings may inadvertently introduce conversion errors due to translation techniques that are unique to individual raters.
8. Encouraging discussions of the position of medical training as one of the main task in hospitals, is a central measure that may enhance the effects of assessment on the learning environment in clerkships and residency programs.
9. Observation should be followed by clear and timely feedback combined with opportunities for learners to practice the competence and demonstrate at a later date their progress on weaknesses identified by assessment.
10. For successful implementation of educational change we should adopt an active participation (educationalists, doctors, residents, and students) who are explicitly involved, motivated to take part in the introduction of the new educational format and in the evaluation of the effects of innovations.
11. The mini-CEX should never be used on its own as a separate assessment tool but should always be combined with other exercises that trainees may perform after patient encounters.